STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: November 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022015

[redacted]

Dear [redacted],

On November 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 19, 2017 disenrollment notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: November 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022015

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine that your Medicaid Managed Care plan enrollment ended August 31, 2017?

Procedural History

On October 21, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of $0.00 was at or below the allowable income limit. This eligibility was effective as of October 1, 2016.

On October 22, 2016, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective December 1, 2016.

On August 2, 2017, NYSOH issued a renewal notice stating it was time to renew your coverage for 2017. The notice stated based on federal and state data sources a decision could not be made about whether you qualified for financial assistance. The notice requested you update the information in your account by September 15, 2017.

On August 18, 2017, NYSOH received your updated application for financial assistance.

On August 19, 2017, NYSOH issued an eligibility determination notice stating you were eligible to enroll in the Essential Plan for a limited time, effective

October 1, 2017. The notice requested you provide proof of your income by November 16, 2017.

On August 19, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan would end August 31, 2017.

On September 1, 2017, you contacted NYSOH's Account Review Unit and requested an appeal insofar as your enrollment in Medicaid had been discontinued as of August 31, 2017 and not September 30, 2017.

On November 7, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

A review of the record supports the following findings of fact:

1) Your application submitted on October 20, 2016 states you expect to file your 2016 federal income tax return as Head of Household, and claim one dependent.

2) According to your application submitted on October 20, 2016 you attested to an annual expected household income for 2016 of $0.00.

3) According to the August 18, 2017 application, you attested to an increased expected annual household income of $19,500.00. You testified that, at the time you submitted your application, this income was an accurate reflection of your expected income for the 2017 tax year.

4) Your application submitted on August 18, 2017 states you will be filing your 2017 taxes as married filing single.

5) You testified you believe your Medicaid coverage should have lasted a full twelve months and should have ended September 30, 2017.

6) You testified you have not had third party health insurance for 2017.

7) You testified you have not moved out of New York in 2017.

8) You reside in [redacted], NY.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2016 FPL, which is $16,020.00 for a two-person household (81 Federal Register 4036).

On the date of your application, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

Generally, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as “continuous coverage” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your Medicaid Managed Care plan ended August 31, 2017.

On October 21, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid because your household income of $0.00 was at or below the allowable income limit. This eligibility was effective as of October 1, 2016. You subsequently enrolled in a Medicaid Managed Care plan, effective December 1, 2016.

You updated your application on August 18, 2017, to include the income you will be receiving from your employment for 2017. This update increased your annual household income to $19,500.00, which is above the Medicaid limit.

On August 19, 2017, NYSOH issued a disenrollment notice stating that you had been disenrolled from your Medicaid Managed Care plan, effective August 31, 2017.

However, under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.”

Credible evidence confirms that you were eligible for Medicaid effective October 1, 2016, and even though your estimated annual income increased when you modified your application on August 18, 2017, you remain eligible for and enrolled in Medicaid for the remainder of your 12-month eligibility period.

12 months from October 1, 2016 would be September 30, 2017. Since you were disenrolled from your Medicaid Managed Care plan coverage prior to the end of your twelve-month period of continuous eligibility and you testified to none of the triggering events which would disqualify you from that coverage, the August 19, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to enroll you into your Medicaid Managed Care plan for the month of September 2017 and to notify you when this change is made.

Decision

The August 19, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to enroll you into your Medicaid Managed Care plan for the month of September 2017 and to notify you when this change is made.

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Effective Date of this Decision: November 29, 2017

How this Decision Affects Your Eligibility

Your Medicaid coverage, which began on October 1, 2016, continues until September 30, 2017.

This decision has no effect over determinations issued after August 19, 2017.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available

to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The August 19, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to enroll you into your Medicaid Managed Care plan for the month of September 2017 and to notify you when this change is made.

Your Medicaid coverage, which began on October 1, 2016, continues until September 30, 2017.

This decision has no effect over determinations issued after August 19, 2017.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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